West Virginia Insurance Commission
Medical Malpractice Insurance Review Standards Checklist

Medical Malpractice		
REVIEW REQUIREMENTS	**REFERENCE**	**COMMENTS**
FORMS		
Fee, filing	§33-6-34	The Filing Fee is $50.00 per Form Filing.
Inclusions	*WVIL* (Informational Letter) 64	Include in the Submission: One Copy of the Filing, Cover Letter describing the nature of the filing Letter (Include the Company's NAIC Identifying Number on the Cover Letter.), One return copy of the Cover letter, Prepaid Mailing Label or Postage Paid Large Envelope
Abstract	*§114-67*	File Appropriate Abstract. Available in Regulations-Series 67.
Filing Standards	**REFERENCE**	**COMMENTS**
Filing Requirements	§33-6-8(a)	No insurance policy form, no group certificate form, no insurance application form where written application is required and is to be made a part of the policy, and no rider, endorsement, or other form to be attached to any policy, shall be delivered or issued for delivery in WV unless it has been filed with and approved by the commissioner, except that as to group insurance policies delivered outside WV, only the group certificates to be delivered or issued for delivery in WV shall be filed for approval.
Time	§33-6-8(b)	Filing must be made not less than sixty days in advance of delivery.
Approval	§33-6-8(b)	After sixty days, a form is considered approved unless express approval or disapproval has been received from the commissioner.
Disapproval	§33-6-8(c)	The commissioner may at any time disapprove or withdraw an approval for a form. The commissioner shall state the grounds for withdrawal or disapproval.
	§33-6-9	Any form shall be disapproved under any of the following conditions:
		1. The form is in violation of or does not comply with Article 6, Chapter 33 of the West Virginia Code.
		2. The form contains or references any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.
		3. The form has any title, heading, or other indication of its provisions which is misleading.
		4. The purchase of such policy is being solicited by deceptive advertising.
		5. The benefits provided therein are unreasonable in relation to the premium charged.
		6. The coverages provided therein are not sufficiently broad to be in the public interest.

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Contents	REFERENCE	COMMENTS
Basic Contents	§33-6-11	Must specify the names of the parties to the contract, the insurer's name, the subject of the insurance, the risks insured against, the time the insurance coverage becomes effective and the term during which such coverage continues, the premium, and the conditions pertaining to the insurance.
Additional Contents	§33-6-12	A policy may contain additional provisions if they are:
		1. consistent with Chapter 33
		2. required to be inserted by the laws of the insurer's domicile
		3. necessary, because of the manner in which the insurer is constituted or operated, in order to state the rights and obligations of the parties
		4. desired by the insurer and not prohibited by law nor in conflict with any provisions required to be included therein and which are considered reasonable and just.
Charter, Bylaws, Other Documents	§33-6-13	No policy shall contain any provision purporting to make any portion of the charter, bylaws, or other constituent document of the insurer a part of the contract unless such portion is set forth in the full policy.
Signature/Countersignature	§33-6-15	Every insurance policy shall be executed in the name of and on behalf of the insurer by its officer, attorney-in-fact, employee, or representative duly authorized by the insurer.
	§33-12-7	No contract of insurance covering a subject of insurance, resident, located, or to be performed in this state, shall be executed, issued or delivered by any insurer unless the contract, or in the case of an interstate risk a countersignature endorsement carrying full information as to the West Virginia risk, is signed or countersigned in writing by a licensed resident agent of the insurer except that excess line insurance shall be countersigned by a duly licensed excess line broker.
Legal Action Against Insurer	§33-6-14	No policy may contain any condition, stipulation or agreement preventing the bringing of an action against the insurer for more than six months after the cause of action accrues or limiting the time within which an action may be brought to a period of less than two years from the time the cause of action accrues in connection with all insurances. Any such condition, stipulation or agreement shall be void, but this shall not affect the validity of the other provisions of the policy.
Arbitration and Appraisal Provisions	*WVIL* 119-B	Arbitration and appraisal provisions are not required but if they are included the language must be equivalent to that set forth in *WVIL* 119-B

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Cancellation & Nonrenewal	REFERENCE	COMMENTS
Notification	§33-20C-3	In every instance in which a policy or contract of malpractice insurance is cancelled by the insurer, the insurer or his duly authorized agent shall cite within the written notice of the action the allowable reason and shall state the specific circumstances giving rise to the cited reason. The notice shall further state that the insured has a right to request a hearing pursuant to §33-20C-5 within 30 days.
	§33-20C-4(a)	Written notice of nonrenewal must be forwarded to the insured by certified mail, return receipt requested, not less than ninety days prior to the expiration date of such policy.
	§33-20C-4(b)	Written notice of cancellation must be forwarded to the insured by certified mail, return receipt requested, not more than 30 days after the reason for such cancellation arose or occurred or the insurer learned that it arose or occurred and not less than 30 days prior to the effective cancellation date.
Permissible Reasons	§33-20C-2	Cancellation may not be issued unless it is based on at least one of the following reasons:
		1. Insured fails to discharge any of his obligations to pay premiums for such policy or any installment thereof within a reasonable time of the due date.
		2. The policy was obtained through material misrepresentation.
		3. The insured violates any of the material terms and conditions of the policy.
		4. The unavailability of reinsurance, upon sufficient proof thereof being supplied to the commissioner.
		Any purported cancellation of a malpractice policy attempted in contravention of these standards shall be void.
Tail Offer	§33-20D-3, §114-30-4	Upon cancellation, nonrenewal or termination of any malpractice policy, the insurer must offer tail coverage, which will expire 45 days after the date of cancellation, nonrenewal or termination of the policy. The tail insurance coverage offer may be accepted sooner, in writing, by the insured.
	§114-30-4, §114-30-5	Upon cancellation, nonrenewal or termination of any malpractice policy, the insurer must offer the opportunity to amortize the quarterly payment of premiums for tail insurance over a period of not more than 36 months. The premium payments shall be amortized at a per annum rate of interest equal to 2 percentage points above the prime interest rate reported in the *Wall Street Journal* on the date when the insurer or its agent receives the insured's written request to purchase tail insurance, or on the next publication date of the *Wall Street Journal* if it is not published on the date when the request is received. The payments must equal at least $750.00.
	§114-30-6	The first quarterly payment shall be payable contemporaneously with the issuance of the tail insurance policy. Subsequent payments shall be due and payable quarterly thereafter.
	§33-20D-3	Each licensed malpractice insurer shall submit for approval, by the commissioner, a plan for determination of partial limits in the event of default on amortized payment.

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Unfair Trade Practices	REFERENCE	COMMENTS
Unfair or Deceptive Practices	§33-11-4	The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance (full definitions and explanations are available in the referenced sections):
		1. Misrepresentation and false advertising of insurance policies
		2. False information and advertising generally
		3. Defamation
		4. Boycott, coercion and intimidation
		5. False statements and entries
		6. Stock operations and advisory board contracts
		7. Unfair discrimination
		8. Rebates
		9. Unfair claim settlement practices
		10. Failure to maintain complaint handling procedures
		11. Misrepresentation in insurance applications
Standards for the Acknowledgment of Pertinent Communications	§114-14-5	1. Acknowledgment of notices of claims – within 15 working days
		2. Answer of inquiries from insurance department – within 15 working days
		3. Replies to other pertinent communications – within 15 working days
		4. Provisions of assistance to first party claimants – Provide necessary claim forms, instructions, and reasonable assistance within 15 working days of notification of a claim.
Standards for Prompt Investigations and Fair and Equitable Settlements Applicable to All Insurers	§114-14-6	All insurers must comply with the following regulations (full explanations are available in §114-14-6):
		1. Investigation of Claims – Investigation must commence within 15 working days of receiving notice of the claim. Must provide a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of the claimant within 15 working days of receiving notice of the claim.
		2. Offers of Settlement – In cases where there is no dispute over coverage or liability, it is the duty of the insurer to offer claimants amounts which are fair and reasonable as shown by its investigation of the claim, providing the amounts offered are within policy limits and provisions.
		3. Denial of Claims – No insurer shall deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to the provision, condition or exclusion is included in the denial.
		4. Records of Denial of Claims – If a denial is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

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Unfair Trade Practices	REFERENCE	COMMENTS
Standards for Prompt Investigations and Fair and Equitable Settlements Applicable to All Insurers	§114-14-6	5. Notice of Necessary Delay in Investigating Claims – If the insurer needs more time with a claim, it shall notice the claimant in writing within 15 working days after receipt of the proofs of loss. If the investigation remains incomplete, the insurer shall send notification within 30 calendar days from the date of initial notification and every 30 calendar days thereafter. The letter shall contain a reason for additional time.
		6. Liability of Others – Insurers must settle claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.
		7. Denial of Claims for Failure to Exhibit Property – No insurer shall deny a claim for failure to exhibit the insured property without proof of demand by the insurer and refusal by the claimant to exhibit the property.
		8. Separation of Claims – If there is no dispute as to one or more elements of a claim, payment for such element(s) shall be made notwithstanding the existence of disputes as to other elements of the claim if payment can be made without prejudice to either party.
		9. Time for Payment of Claims – Insurers must pay the amount agreed upon no later than 15 working days from the receipt of the agreement or from the date of the performance by the claimant of any condition set by such agreement, whichever is later.
		10. Notice of Applicable Time Limitations – No person shall negotiate for settlement of a claim with a claimant who is neither an attorney nor represented by an attorney without giving the claimant written notice that the claimant's rights may be affected by a statute of limitations or a policy or contract time limit. Such notice shall be given to first party claimants 30 days and to third party claimants 60 days before the date on which the time limit may expire.
		11. Avoidance of Payment – Where liability and damages are reasonably clear, no person shall recommend that third party claimants make claim under their own policies solely to avoid paying claims under an insurer's insurance policy or insurance contract.
		12. Unreasonable Travel – No person shall require a claimant to travel unreasonably to inspect a replacement motor vehicle, to obtain a repair estimate or to have the motor vehicle repaired at a specific repair shop.

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Rate Filing	REFERENCE	COMMENTS
Fee, filing	§33-6-34	The Filing Fee is $75.00 per Rate Filing, and $75.00 per Rule Filing.
Inclusions	*WVIL* (Informational Letter) 64	Include in the Submission: One Copy of the Filing, Cover Letter describing the nature of the filing Letter (Include the Company's NAIC Identifying Number on the Cover Letter.), One return copy of the Cover letter, Prepaid Mailing Label or Postage Paid Large Envelope
Basic Requirements	§33-20B-3(a)	Every filing for malpractice insurance made pursuant to subsection (a), section four, article twenty of this chapter shall state the proposed effective date of the filing, the character and extent of the coverage contemplated and information in support of the filing. The information furnished in support of a filing shall include: (i) The experience or judgment of the insurer or rating organization making the filing; (ii) its interpretation of any statistical data the filing relies upon; (iii) the experience of other insurers or rating organizations; and (iv) any other relevant factors required by the commissioner. When a filing is not accompanied by the information required by this section upon which the insurer supports the filing, the commissioner shall require the insurer to furnish the information and, in that event, the waiting period prescribed by subsection (b) of this section shall commence as of the date the information is furnished.
	§33-20B-3(b)	Every filing shall be on file for a waiting period of ninety days before it becomes effective. The commissioner may extend the waiting period for an additional period not to exceed thirty days if he or she gives written notice within the waiting period to the insurer or rating organization which made the filing that he or she needs the additional time for the consideration of the filing. Upon written application by the insurer or rating organization, the commissioner may authorize a filing which he or she has reviewed to become effective before the expiration of the waiting period or any extension of the waiting period. A filing shall be deemed to meet the requirements of this article unless disapproved by the commissioner within the waiting period or any extension thereof.
	§33-20B-3(c)	No insurer shall make or issue a contract or policy of malpractice insurance except in accordance with the filings which are in effect for the insurer as provided in this article.
Abstract	*§114-67*	File Appropriate Abstract. Available in Regulations-Series 67.

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Requirements	REFERENCE	COMMENTS
Consent-to-Rates and Guide "A" Rates	*§114-59-3(3.1)*	Any insurer that wishes to negotiate consent to rate agreements or apply guide “a” rates in connection with the issuance or renewal of any policy providing coverage for medical malpractice liability, shall first file with the commissioner as part of its filing made pursuant to subsection 33-20B-3(a) of the West Virginia Code, or as a supplement to the filing, an appendix which describes the specific risks or reasons for which non-standard rates will be applied to particular risks. The appendix must also set forth the ranges of rates that will be applied to risks that may be the subject of consent to rate agreements: *Provided,* that the appendix is not required to include rate ranges that will apply to guide “a” rates.
	§114-59-3(3.2)	An insurer shall obtain from the insurance applicant all information necessary to determine the proper application of a non-standard rate before seeking approval from the commissioner of a consent to rate agreement or guide “a” rate. The application for approval of a consent to rate agreement or the use of a guide “a” rate in connection with a specific risk shall be signed by the insured and the insurer, and shall be submitted by the insurer on the West Virginia Medical Malpractice Policy Agreement form, Appendix A to this rule. The original and one copy of the application shall be filed and shall be accompanied by a filing fee of $25.00 and a self-addressed postage prepaid envelope. Resubmission of a disapproved filing will require an additional filing fee. The filing fee shall be paid by the insurer and may not be passed on to the insured.
	§33-20B-2(e)	An insurer may use guide "A" rates and other nonapproved rates, also known as "consent to rates": Provided, That the insurer shall, prior to entering into an agreement with an individual provider or any health care entity, submit guide “A” rates and other nonapproved rates to the commissioner for review and approval

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Requirements	REFERENCE	COMMENTS
Disapproval	§33-20B-4	During the waiting period, if the commissioner finds that a filing does not meet all requirements, he shall send to the insurer or rating organization written notice of disapproval specifying in what respects he finds such filing fails to meet the requirements and stating that such filing shall not be effective. Within 30 days from the issuance of written notice of disapproval, any insurer or rating organization may request a hearing pursuant to §33-2-13.
		If at any time after the waiting period or extension thereof the commissioner finds that a filing does not meet all requirements, he shall send a written order specifying the reason the filing does not meet the requirements and a date, not less than 30 days from the issuance of such order, when the filing shall be deemed no longer effective. Within 30 days from the issuance of such order, any insurer or rating organization may request a hearing thereon pursuant to §33-2-13. Any such order shall not affect any contract or policy made or issued prior to the expiration date set forth in such order.
		Any person or organization aggrieved by any filing which is in effect or the application thereof may request a hearing pursuant to §33-2-13. The insurer or rating organization which made such filing shall be notified in writing upon receipt of any such request and thereby be made a party to such hearing. Upon the hearing, if the commissioner finds the filing fails to meet all requirements, he shall issue an order pursuant to §33-20B-4(b).
Required Hearing for 10% or Higher	§33-20B-4(d)	Within the initial 90 day waiting period, the commissioner shall hold a public hearing upon every filing which requests an increase in general rates of ten percent or more and upon every filing which, in the commissioner's opinion, is of such import that it will affect the public. The insurer or rating organization will be notified not less than 15 days prior to the hearing date. Notice of the time, place and filing to be considered shall be published as a Class II legal advertisement in every county in the state in accordance with §59-3-1 et seq.